STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011970	A. BUILDING: _____ B. WING _____	R 04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Licensure Survey completed on March 17, 2016. Survey date: 4/21/16 Facility number: 011970 Provider number: 011970 AIM number: N/A Census bed type: Residential: 38 Total: 38 Census payor type: Medicaid: 24 Other: 14 Total: 38 Sample: 4 Vermillion Place was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-5 in regard to the PSR to the State Licensure Survey. QR completed by 11474 on April 22, 2016.	{R 000}		